

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4572

CERTIFICATE OF DEATH

Reg. Dist. No.

04572

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winter Quarters Drive		d. STREET ADDRESS Winter Quarters Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maude Middle L. Last Clapper		4. DATE OF DEATH Month April Day 10 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1876
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Williams Charles A. Clapper		14. MOTHER'S MAIDEN NAME Laura Cottingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT LeRoy E. Conant, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Failure DUE TO (c) Degenerative Heart Disease, Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 29, 1955 to Apr. 10, 1956 , that I last saw the deceased alive on Apr. 10, 1956 , and that death occurred at 2:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader, M.D.		ADDRESS (Street, city or town, state) Pocomoke City, Md.	
DATE SIGNED 4-12-56			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-56	
22c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		22d. LOCATION (City, town, or county) (State) Oak Hall, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke, Md.	
24a. REC'D BY REGISTRAR APR 16 1956		24b. REGISTRAR'S SIGNATURE Dore H. H. H.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]		7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]		9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]		11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JUDGE [Faint text]		17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]		19. SIGNATURE OF [Faint text]		20. SIGNATURE OF [Faint text]		21. SIGNATURE OF [Faint text]		22. SIGNATURE OF [Faint text]		23. SIGNATURE OF [Faint text]		24. SIGNATURE OF [Faint text]		25. SIGNATURE OF [Faint text]		26. SIGNATURE OF [Faint text]		27. SIGNATURE OF [Faint text]		28. SIGNATURE OF [Faint text]		29. SIGNATURE OF [Faint text]		30. SIGNATURE OF [Faint text]		31. SIGNATURE OF [Faint text]		32. SIGNATURE OF [Faint text]		33. SIGNATURE OF [Faint text]		34. SIGNATURE OF [Faint text]		35. SIGNATURE OF [Faint text]		36. SIGNATURE OF [Faint text]		37. SIGNATURE OF [Faint text]		38. SIGNATURE OF [Faint text]		39. SIGNATURE OF [Faint text]		40. SIGNATURE OF [Faint text]		41. SIGNATURE OF [Faint text]		42. SIGNATURE OF [Faint text]		43. SIGNATURE OF [Faint text]		44. SIGNATURE OF [Faint text]		45. SIGNATURE OF [Faint text]		46. SIGNATURE OF [Faint text]		47. SIGNATURE OF [Faint text]		48. SIGNATURE OF [Faint text]		49. SIGNATURE OF [Faint text]		50. SIGNATURE OF [Faint text]		51. SIGNATURE OF [Faint text]		52. SIGNATURE OF [Faint text]		53. SIGNATURE OF [Faint text]		54. SIGNATURE OF [Faint text]		55. SIGNATURE OF [Faint text]		56. SIGNATURE OF [Faint text]		57. SIGNATURE OF [Faint text]		58. SIGNATURE OF [Faint text]		59. SIGNATURE OF [Faint text]		60. SIGNATURE OF [Faint text]		61. SIGNATURE OF [Faint text]		62. SIGNATURE OF [Faint text]		63. SIGNATURE OF [Faint text]		64. SIGNATURE OF [Faint text]		65. SIGNATURE OF [Faint text]		66. SIGNATURE OF [Faint text]		67. SIGNATURE OF [Faint text]		68. SIGNATURE OF [Faint text]		69. SIGNATURE OF [Faint text]		70. SIGNATURE OF [Faint text]		71. SIGNATURE OF [Faint text]		72. SIGNATURE OF [Faint text]		73. SIGNATURE OF [Faint text]		74. SIGNATURE OF [Faint text]		75. SIGNATURE OF [Faint text]		76. SIGNATURE OF [Faint text]		77. SIGNATURE OF [Faint text]		78. SIGNATURE OF [Faint text]		79. SIGNATURE OF [Faint text]		80. SIGNATURE OF [Faint text]		81. SIGNATURE OF [Faint text]		82. SIGNATURE OF [Faint text]		83. SIGNATURE OF [Faint text]		84. SIGNATURE OF [Faint text]		85. SIGNATURE OF [Faint text]		86. SIGNATURE OF [Faint text]		87. SIGNATURE OF [Faint text]		88. SIGNATURE OF [Faint text]		89. SIGNATURE OF [Faint text]		90. SIGNATURE OF [Faint text]		91. SIGNATURE OF [Faint text]		92. SIGNATURE OF [Faint text]		93. SIGNATURE OF [Faint text]		94. SIGNATURE OF [Faint text]		95. SIGNATURE OF [Faint text]		96. SIGNATURE OF [Faint text]		97. SIGNATURE OF [Faint text]		98. SIGNATURE OF [Faint text]		99. SIGNATURE OF [Faint text]		100. SIGNATURE OF [Faint text]	
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BUREAU V. S.

APR 16 1956

RECEIVED

4574

CERTIFICATE OF DEATH

Reg. Dist. No.

04573

358

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b All life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Maple Ave.		d. STREET ADDRESS Maple Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Hammond		4. DATE OF DEATH Month 4 Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaping		10b. KIND OF BUSINESS OR INDUSTRY Briddell Firm	
11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2-10-12-60112	
17. INFORMANT Mrs. Raymond Hammond, Maple Ave., Berlin, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus of femoral artery DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8-10 hrs 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/27 , 19 54 , to 4/24 , 19 56 , that I last saw the deceased alive on 4/24 , 19 56 , and that death occurred at 8:10 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry U. Shely, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin, Md.	
PHYSICIAN'S NAME (Type) Harry U. Shely, Jr.		DATE SIGNED 4/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-28-56	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		ADDRESS Home, Salisbury, Md.	
24a. REC'D BY REGISTRAR 4/27/56		24b. REGISTRAR'S SIGNATURE Helen F. Hayward	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		1910		Maryland		Baltimore		Maryland		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
April 28, 1956		10:30 AM		Home		Heart Disease		Natural		Myocardial Infarction		Chest Pain, Shortness of Breath		Medication, Rest	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
Teacher		High School		Roman Catholic		Married		Yes		No		No		No	
FAMILY HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF NOTARY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
APR 30 1956
BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4575

CERTIFICATE OF DEATH

04574

Reg. Dist. No. 355

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>WORCESTER</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>WORCESTER</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OCEAN CITY</u>	LENGTH OF STAY (in this place) <u>50 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OCEAN CITY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>TALBOT ST.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>SIGNE</u> (Middle) <u>VICTORIA</u> (Last) <u>HARMON</u>		(Month) <u>APRIL</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>	8. DATE OF BIRTH <u>MAR. 22, 1882</u>
		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>GOTTENBURG, SWEDEN</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ALFRED JOHANSON</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT & ADDRESS <u>MR. ALFRED HARMON OCEAN CITY MD</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE (A) <u>Senile Dementia</u>			<u>3400</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cerebro-vascular disease</u>			<u>6905</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>1948</u> , to <u>3 Apr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 Apr</u> , 19 <u>56</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William R. Thomas</u> M.D.		ADDRESS (Street, city, town, state) <u>Ocean City</u>	
DATE SIGNED <u>4 Apr 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>4-5-56</u>	NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Helen A. Hayward</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdige</u>	ADDRESS <u>Berlin Md</u>
DATE <u>4-5-56</u>			

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. MEDICAL CERTIFICATION

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF REGISTRAR

24. SIGNATURE OF PHYSICIAN

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF PHYSICIAN

27. SIGNATURE OF REGISTRAR

BUREAU V. S.

APR 9 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4576 CERTIFICATE OF DEATH

04575
Reg. Dist. No. 355

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Route # 3				d. STREET ADDRESS Route # 3			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hennie Middle Elizabeth Last Hudson				4. DATE OF DEATH Month 4 Day 21 Year 1956			
5. SEX Female		6. COLOR OR RACE A. A.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Houseswork		11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.	
13. FATHER'S NAME Daniel Pitts				14. MOTHER'S MAIDEN NAME Maggie Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Maggie Hudson, Berlin, Md. Rt. # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Parkinsonism (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days Several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 19 54 , to 4/21 , 19 56 , that I last saw the deceased alive on 4/21 , 19 56 , and that death occurred at 3:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 4/23/56							
ACTUAL SIGNATURE Harry U. Shelly, Jr. M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-56		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart ADDRESS Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE 4/26/56		24b. REGISTRAR'S SIGNATURE Helen F. Hayward	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4577

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WORCESTER.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>35 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY RICHARDSON JACKSON</u>		4. DATE OF DEATH Month Day Year <u>APRIL 25 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWARK, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN RICHARDSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SULLIVAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Brights with Dropsy</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chc Myocarditis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 14 - 1956</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 23 - 1956</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. P. Saw</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>April 26-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCH</u>
22d. LOCATION (City, town, or county) <u>BERLIN</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Berna A. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Helen J. Hayward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

RECEIVED
 APR 30 1956
 BUREAU V. 8

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
RACE [Faint text, possibly "W"]		BIRTH DATE [Faint text, possibly "11-15-11"]		BIRTH PLACE [Faint text, possibly "BALTIMORE, MD"]	
DECEASED AT [Faint text, possibly "HOME"]		PLACE OF DEATH [Faint text, possibly "BALTIMORE, MD"]		DATE OF DEATH [Faint text, possibly "4-25-56"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]	
SIGNATURE OF DECEASED [Faint text, possibly "JOHN DOE"]		SIGNATURE OF WITNESS [Faint text, possibly "JANE DOE"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "DR. J. SMITH"]	
SIGNATURE OF CLERK [Faint text, possibly "J. SMITH"]		SIGNATURE OF REGISTRAR [Faint text, possibly "J. SMITH"]		SIGNATURE OF DEPUTY REGISTRAR [Faint text, possibly "J. SMITH"]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04577

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u> c. LENGTH OF STAY IN 15 <u>part of the evening</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R21D</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City Md</u> d. STREET ADDRESS <u>R21D</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Chauncy McKinley Johnson</u> First Middle Last				4. DATE OF DEATH <u>April 20</u> 19 <u>56</u> Month Day Year											
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14 '93</u>		9. AGE (In years last birth day) <u>26</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>26</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Georgetown</u>				11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Norman Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Crbin</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>214-28-2982</u>				17. INFORMANT <u>Norman Johnson</u>				18. CAUSE OF DEATH (Enter only one cause past for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain laceration hemorrhage</u> DUE TO (b) <u>Bullet wound 1 inch above left temple</u> DUE TO (c) <u>2 in. 1/2 in. Pistol</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>During a fight a 3rd party - the accused fired fatal shot</u>											
20c. TIME OF INJURY Month, Day, Year <u>April 20 1956</u> Hour o. m. <u>11</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Chicken Shack</u>		20f. City or town <u>Rural Pocomoke</u>		20g. (County) <u>Worcester</u>		20h. (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/> and find that death resulted from: Natural causes <input type="/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> 															
ACTUAL SIGNATURE <u>N. E. Sartorius</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4/20/56</u>							
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>4/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Chapel</u>				22d. LOCATION (City, town, or county) <u>Pocomoke</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar White</u>				ADDRESS <u>New Church</u>				24a. REC'D BY REGISTRAR <u>4/24/56</u>				24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please eye-
 cut the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

1
100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK DEPARTMENT OF HEALTH ALBANY ONE 13

BUREAU V. E.

APR 26 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04578

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In transit to P. G. Hospital</u>				d. STREET ADDRESS <u>R 2nd</u>			
3. NAME OF DECEASED (Type or print) <u>Shax Les</u> First <u>Wm</u> Middle <u>Dones</u> Last				4. DATE OF DEATH <u>April 22</u> Month <u>19</u> Day <u>56</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15-1923</u>		9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tractor</u>		11. BIRTHPLACE (State or foreign country) <u>Pennson Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Thomas Jones</u>				14. MOTHER'S MAIDEN NAME <u>Leona Paulson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>201-124545</u>		17. INFORMANT <u>Richard Brooks in law Pocomoke Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal (abdominal) hemorrhage</u> DUE TO <u>Cut Intestinal & Mesentery Blood vessels</u> DUE TO <u>Deep abdominal cut</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Sliced by an unknown work of neck down the spine</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Henry's Right</u>		20f. (City or town) <u>Pocomoke (Rural) Worcester Md</u>		20g. (County) <u>Worcester</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pocomoke Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pocomoke City (R2D) Md</u>				22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				23b. ADDRESS <u>Pocomoke Md</u>		24a. REC'D BY REGISTRAR <u>APR 25 1956</u>	
23c. NAME OF REGISTRAR <u>APR 25 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Eme Whiter</u>			

BUREAU V. S.

APR 25 1956

RECEIVED

4580

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>GREEN ACRES</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WASHINGTON JOHN McCABE</u>		4. DATE OF DEATH Month Day Year <u>APRIL 8 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WW</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSHUA McCABE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ANNE TIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	
17. INFORMANT Address <u>Mrs. W.S. McCABE, BERLIN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>30 minute</u> <u>2 1/2</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> to <u>8 Apr</u> , 1956, that I last saw the deceased alive on <u>2 Apr</u> , 1956, and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u> DATE SIGNED <u>9d 10 Apr 56</u>	
PHYSICIAN'S NAME (Type) <u>A.R. Thomas MD</u>		<u>Ocean City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/10/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u> ADDRESS <u>Berlin, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Helen B. Hayward</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 12 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

350

4581

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beverly Manor		e. STREET ADDRESS Beverly Manor	
3. NAME OF DECEASED (Type or print) First Bessie Middle Lee Last McLean		4. DATE OF DEATH Month April Day 15 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1878
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. McLean		14. MOTHER'S MAIDEN NAME Belinda Ann Waterfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs Arthur F. Shettle, Pocomoke, Md.		Address Pocomoke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 443X DUE TO CERERO VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPER TENSIVE CARDIO VASCULAR DISEASE DUE TO 10YRS (c) 10YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10YRS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC 1 , 19 55 , to APR 14 , 19 56 , that I last saw the deceased alive on APR 15 , 19 56 , and that death occurred at 12:10 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Stanford Hamilton		ADDRESS (Street, city or town, state) FRONT ST.	
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON		DATE SIGNED Pocomoke City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-17-56	22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	22d. LOCATION (City, town, or county) (State) Norfolk Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Denny H. Watson		24. REC'D BY REGISTRAR 17 1956	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Gene White	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4582

CERTIFICATE OF DEATH

Reg. Dist. No.

04581
355

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin				c. LENGTH OF STAY IN 1b Most of life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Route # 3				d. STREET ADDRESS Route # 3			
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Miller				4. DATE OF DEATH Month 4 Day 10 Year 1956			
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4, 1888		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abel Purnell				14. MOTHER'S MAIDEN NAME Sallie Purnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Miss Pearl Miller, Berlin, Md. Route # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 443X DUE TO Cerebral vascular accident with right hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertensive Cardio-vascular Disease (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 7 1/2 mos Several yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18, 1954 to 4/10, 1956 , that I last saw the deceased alive on 4/10, 1956 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 4/14/56							
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.				PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-56		22c. NAME OF CEMETERY OR CREMATORY Germantown Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart ADDRESS Stewart Funeral Home Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 4/15/56		24b. REGISTRAR'S SIGNATURE Helon F. Hayward	

BUREAU V. S.

APR 18 1956

RECEIVED

4583

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				c. LENGTH OF STAY IN 1b <u>50 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLEN RADCLIFFE MUMFORD</u>				4. DATE OF DEATH Month Day Year <u>APRIL 17 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 20, 1899</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>ICE MANUFACTURE</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>IRVING S. MUMFORD</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA M. MUMFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-6289</u>		17. INFORMANT Address <u>MRS. A. R. MUMFORD BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic endocarditis</u> 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic fever</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Biliary cancer of liver</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> , to <u>17 Apr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 Apr</u> , 19 <u>56</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. P. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u>			
PHYSICIAN'S NAME (Type) <u>N. P. Thomas</u>				DATE SIGNED <u>Ocean City, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>4/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Diana A. Burbox</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE 4-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. 31

APR 23 1956

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

4584

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH - COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin R.F.D.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Md.</i>	
TOWN <i>Berlin</i>		TOWN <i>Berlin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>R.F.D.</i>	
3. NAME OF DECEASED (Type or Print) <i>Claron</i> (First) <i>Teter</i> (Middle) <i>Teter</i> (Last)		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>25</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>Dec 26, 1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	9. AGE last birthday <i>88</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Berlin W. Va.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Cyance Teter</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Cyance Teter Berlin Md.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <i>Coronary heart failure</i>		?
(b) Antecedent cause(s) <i>Cerebral Apoplexy</i>		?
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Hypertension</i>		?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Q.E.S.</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>4-25-56</i>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-1-56*, 19*56*, to *4-25-56*, 19*56*, that I last saw the deceased

alive on *4-24-56*, and that death occurred at *8:45 A.M.*, from the causes and on the date stated above.

SIGNATURE *Clifton E. Scholtz M.D.* ADDRESS *Berlin Md.* DATE SIGNED

23. BURIAL OR CREMATION (Specify) <i>Burial</i>	DATE <i>April 28, 1956</i>	NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>	LOCATION (City, town, or county) <i>Berlin Md.</i>
DATE REC'D BY LOCAL REG. <i>4/26/56</i>	REGISTRAR'S SIGNATURE <i>Helen S. Hayward</i>	24. FUNERAL DIRECTOR <i>Peter Whaley</i>	ADDRESS <i>Silveryville</i>

MARGIN RESERVED FOR BINDING

BUREAU V. B.

APR 30 1956

RECEIVED

4585

CERTIFICATE OF DEATH

04584

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin c. LENGTH OF STAY IN 1b Most of life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Route # 3		d. STREET ADDRESS Route # 3	
3. NAME OF DECEASED (Type or print) First Rachel Middle Anne Last Washington		4. DATE OF DEATH Month 4 Day 21 Year 1956	
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Pitts		14. MOTHER'S MAIDEN NAME Sarah Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas Pitts, Berlin, Worcester Co. Md. Rt. #3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Cerebral Apoplexy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 334X (c) ?		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-15-56 , to 4-21-56 , that I last saw the deceased alive on 4-20-56 , 19 56 , and that death occurred at 7:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED Clifford E. Schott			
ACTUAL SIGNATURE Clifford E. Schott M.D. Berlin Md			
PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT BERLIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-26-56	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart 2. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE 4/27/56	24b. REGISTRAR'S SIGNATURE Helen J. Hayward

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York		Heart Disease		Jan 15, 1956		10:30 AM	
Usual Residence		Occupation		Marital Status		Social Security Number	
123 Main St, Baltimore, MD		Teacher		Married		123-45-6789	
Physician		Hospital		Burial Place		Burial Date	
Dr. J. Smith		St. Mary's Hospital		Catholic Cemetery		Jan 18, 1956	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 APR 30 1956
 BUREAU V. S.

4586

CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b Most of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - 501 Ross Street		d. STREET ADDRESS 501 Ross Street	
3. NAME OF DECEASED (Type or print) First Harrison Middle Benjamin Last Waters		4. DATE OF DEATH Month 4 Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE A.A.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chicken Plant	
11. BIRTHPLACE (State or foreign country) Snow Hill, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Waters		14. MOTHER'S MAIDEN NAME Lydia Collick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Margie Waters, 501 Ross St., Snow Hill, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia - 1953		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1953, to April 25, 1956 , that I last saw the deceased alive on 4/25/56 , 19, and that death occurred at 11:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. F. Stewart M.D.		ADDRESS (Street, city or town, state) 104 Bay St. Snow Hill Md. DATE SIGNED 4/27/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-29-56	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	22d. LOCATION (City, town, or county) (State) Snow Hill, Worcester Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DR 30 1956	
24b. REGISTRAR'S SIGNATURE Anne White			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 4580
 CERTIFICATE OF DEATH

DATE OF DEATH 1956		PLACE OF DEATH HOME	
AGE 70		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Retired		MARRIAGE Married	
DATE OF BIRTH 1886		PLACE OF BIRTH Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover	
DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956	

RECEIVED
 APR 30 1956
 BUREAU V. S.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04586
350

4573

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 600 Walnut Street		d. STREET ADDRESS 600 Walnut Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Vaughn W. Wilkinson		4. DATE OF DEATH Month Day Year April 28 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY Produce Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Wilkinson		14. MOTHER'S MAIDEN NAME Lillie Seabrease	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW #1		16. SOCIAL SECURITY NO. 213-01-8881	
17. INFORMANT Mrs Emma B. Wilkinson, Pocomoke, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY Occlusion DUE TO (b) Atherosclerosis of CORONARY Arteries DUE TO (c) 3 to 4 years INTERVAL BETWEEN ONSET AND DEATH 3 to 4 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 19 47, to 28 April, 19 56, that I last saw the deceased alive on 21 Nov. 19 55, and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE N. E. Sartorius, Jr.		ADDRESS (Street, city or town, state) 114 Market St., Pocomoke, Md.	
PHYSICIAN'S NAME (Type) N. E. Sartorius, Jr.		DATE SIGNED 30 April 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-56	
22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR DATE 5/2/56	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Anne White	

RECEIVED

JUN 2 1956

BUREAU V. 2

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. OCCUPATION [REDACTED]		11. MARITAL STATUS [REDACTED]		12. EDUCATION [REDACTED]	
13. RELIGION [REDACTED]		14. RACE [REDACTED]		15. ETHNIC ORIGIN [REDACTED]	
16. SOCIAL SECURITY NUMBER [REDACTED]		17. MEDICAL HISTORY [REDACTED]		18. PRESENT ILLNESS [REDACTED]	
19. PHYSICIAN'S SIGNATURE [REDACTED]		20. MEDICAL EXAMINER'S SIGNATURE [REDACTED]		21. CORONER'S SIGNATURE [REDACTED]	
22. COUNTY CLERK'S SIGNATURE [REDACTED]		23. STATE CLERK'S SIGNATURE [REDACTED]		24. FEDERAL CLERK'S SIGNATURE [REDACTED]	